California Behavioral Health Planning Council

Advocacy • Evaluation • Inclusion

AGENDA

January 19, 20, 21, and 22, 2021

Notice: All agenda items are subject to action by the Council. Scheduled times on the agenda are estimates and subject to change. If Reasonable Accommodation is required, please contact the Council at 916.323.4501 by January 5, 2021 in order to meet the request. All items on the Committee agendas posted on our website are incorporated by reference herein and are subject to action.

COMMITTEE MEETINGS

Tuesday, January 19, 2021

2:00pm	Performance Outcomes Committee

Wednesday, January 20, 2021

8:30am	Executive Committee
10:30am	Patients' Rights Committee
1:30pm	Workforce and Employment Committee
3:30 pm	Reducing Disparities Workgroup

Thursday, January 21, 2021

8:30am	Housing and Homelessness Committee
10:30am	Systems and Medicaid Committee
1:30pm	Legislation Committee

Friday, January 22, 2021

COUNCIL GENERAL SESSION
Zoom

9:00am	**Welcome and Introductions** *Lorraine Flores, Chairperson*	
9:10am	**Approval of January 2020 Meeting Minutes** *Lorraine Flores, Chairperson*	**Tab E**
9:15am	**Election of 2021 Chairperson-Elect and Changing of the Officers** *Nominating Committee Members: Karen Baylor, John Black, Lorraine Flores, Cheryl Treadwell, Susan Wilson*	
9:25am	**Department of Health Care Services Update** *Kelly Pfeifer, M.D., and Jim Kooler, Dr.P.H., and Shaina Zurlin*	
9:50pm	**Public Comment**	
10:00am	**Break**	
10:05am	**Member Discussion of Council Priorities for 2021** *Noel O'Neill, Chairperson*	**Tab F**
10:50am	**Public Comment**	
10:55am	**Closing Remarks**	
11:00am	**Adjourn**	

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2021 Council Meeting Schedule

April 13-16, 2021

June 15-18, 2021

October 19-22, 2021

2022 Council Meeting Schedule

January 18-21, 2022

April 19-22, 2022

June 14-17, 2022

October 18-21, 2022

TAB E

California Behavioral Health Planning Council
General Session
Friday, January 21, 2021

Agenda Item: Approve January 2020 Meeting Minutes

Enclosures: Draft January 2020 Meeting Minutes

Background/Description:

Attached are the draft meeting minutes for member review and approval.

CALIFORNIA BEHAVIORAL HEALTH PLANNING COUNCIL MEETING MINUTES

January 14-17, 2020
Holiday Inn San Diego Bayside
4875 N Harbor Drive
San Diego, CA 92106

CBHPC Members Present:

Lorraine Flores, Chair
Noel O'Neill, Chair-Elect
Karen Baylor
John Black
Monica Caffey
Vera Calloway
Christine Costa
Niki Dhillon
Christine Frey
Karen Hart
Celeste Hunter
Veronica Kelley
Steve Leoni
Barbara Mitchell
Iris N. Mojica de Tatum
Catherine Moore
Kathi Mowers-Moore
Dale Mueller
Monica Nepomuceno
Liz Oseguera
Deborah Pitts
Darlene Prettyman
Hector Ramirez
Marina Rangel
Daphne Shaw
Walter Shwe
Julie Souliere
Sokhear Sous
Deborah Starkey
Cheryl Treadwell
Arden Tucker
Tony Vartan
Gerald White
Susan Wilson

Staff Present:

Jane Adcock, Executive Officer
Jenny Bayardo
Justin Boese
Ashneek Nanua
Eva Smith

Thursday, January 16, 2020: Council General Session

1. Welcome and Introductions

Chair Lorraine Flores welcomed the Planning Council members to the meeting and invited them to introduce themselves. They stated their affiliations and counties.

Chairperson Flores introduced new member Christine Frey, a youth advocate.

2. County Behavioral Health Directors Association Update

Michelle Doty Cabrera, CBHDA Executive Director, provided the update.

The CBHDA Board met in the fall to set priorities for 2020, which she explained as follows:

California Advancing and Innovating Medi-Cal (CalAIM) is a reform effort within the state's Medi-Cal program. In consultation with the county Mental Health Directors, the state has put forward a proposal to look at transforming how we pay for care, rules for eligibility, and what the systems look like. The drive is for simplicity and integration of mental health and substance use disorder services.

CBHDA will be involved in the coming reform/revise of the Mental Health Services Act (MHSA).

Senator Bell's Peer Certification bill was vetoed by the Newsome administration. He has reintroduced it as SB 803 with the CBHDA as a cosponsor.

CBHDA is hoping to introduce legislation that strengthens the role of county mental health in schools.

CBHDA asked the administration to forward several proposals related to the state budget. The biggest ask was for $500 million for one year as a stopgap on board and care facilities. We are losing board and care capacity, which is important in preventing clients from ending up in higher levels of institutional care as well as in homelessness.

CBHDA also requested for the administration to work with them on another waiver to bring in extra funding for more stability in the board and care part of the delivery system.

CBHDA asked the Governor for $250 million to invest in mental health diversion; they also asked for funding for peers.

Ms. Cabrera spoke about budget highlights. In a pre-January budget announcement, the Governor partially met the CBHDA's board and care request; on homelessness, he is proposing to put $750 million into a flexible housing pool. Ms. Cabrera did not feel that it is a good idea to pit the rental subsidy prevention piece of addressing homelessness against board and cares. It is important to prevent people from falling into homelessness, and for the vast majority of people doing so each year in California, their mental health or substance use disorder condition, should they have one, is not the driving factor – it is their very low income and lack of affordable housing.

The Governor proposed to create a behavioral health task force at the level of the California Health and Human Services Agency (CHHS). The intention is for the Administration to pull together all the different agency departments across CHHS along with outside stakeholders, to start to advise the Administration on behavioral health issues in a coordinated fashion.

The largest program that the State runs, by far, is Medi-Cal. With federal, state, and local funds coming in, the program is about $103 billion total. Of the state's $103 billion in Medi-Cal, county behavioral health gets about $5.2 billion from the 1991 Realignment, 2011 Realignment, and MHSA funds. This $5.2 billion is intended to support both the Medi-Cal population, the services and supports not covered by Medi-Cal, and the population that does not qualify for Medi-Cal.

The Legislative Analyst's Office estimates that the Governor will have around $7 billion of surplus this year. They estimate that around $3 billion could go toward ongoing programs.

We did not get the $250 million for diversion; so for the board and care full $500 million, the diversion, and the peers proposal, CBHDA is going to ask individual lawmakers to submit those concepts into the budget process via the Legislature. If approved in the Assembly and the Senate, the Administration will have to negotiate with the Legislature about those priorities.

As well as behavioral health, another significant priority for the Governor is homelessness. He has prioritized three areas for the Council of Regional Homeless Advisors: ending street homelessness, expanding access to treatment for mental health and substance use disorder (SUD), and producing more housing stock. The CBHDA and other stakeholders submitted a fourth prong: preventing people from falling into homelessness in the first place. The Planning Council did take up that recommendation for the Governor.

The new big idea for the homeless crisis is creating an obligation for government to provide housing options for people in California. On homelessness, everything the government does is entirely voluntary. There is a lack of coordination and accountability among all the different state entities that touch homelessness – there is no one central clearinghouse entity that is responsible. The Governor wants to explore this idea.

There have been hints that people want to direct more of MHSA funding to the homelessness crisis. The CHBDA stands by its record on MHSA and homelessness. They are contributing around $750 million toward homelessness on an annual basis.

Another big idea is to open MHSA funds to be spent on SUDs. It can be hard to "deconstruct" a person with SUD to discern an underlying serious or mild-to-moderate mental illness and place the person in an appropriate program.

A hot topic that will appear in the Legislature this year is reform of the Lanterman-Petris-Short (LPS) Act – the body of law that governs forced treatment for individuals with serious mental illness (5150s, conservatorship, etc.). Last year the Steinberg Institute and other stakeholders asked for an audit of the LPS Act; it is due in April 2020.

Questions and Discussion

Ms. Baylor asked if the purpose of expanding MHSA to include substance use is part of a greater design of moving away from buckets of money and giving counties more flexibility. Ms. Cabrera confirmed. She added that the Governor had voiced strong words on mental health parity, saying he was going to be directing the Department of Managed Health Care, which has regulatory oversight of health plans in California, to more thoroughly enforce parity laws in California. The bigger problems in terms of parity exist on the commercial side.

Ms. Shaw asked about the issue of removing county authority in the possible reform of the MHSA. Ms. Cabrera responded that there is currently a piece in the conversation of eliminating the funding percentages that say you must spend 80% on Community Support

Services (CSS) and 20% on Prevention and Early Intervention (PEI). Instead, counties would be held accountable for achieving certain outcomes. CBHDA's perspective is that it would not make sense to say in law what those outcomes should be; needs change and measurable data changes. Today, the MHSA already requires us to look at the seven negative outcomes which include homelessness, justice, and youth. Measuring prevention is very difficult. Whatever we set at the state level for outcomes/goals should include a role for the local community planning process to inform how we move toward those goals.

Ms. Shaw referenced the importance of stakeholder input – the voice of the client, the family member, and others. She was concerned that it would go by the wayside. Ms. Cabrera agreed that those concerns are well-founded in that when the deciders meet to decide on a policy, they are going to be influenced by what they know and what they think matters. As an advocate, she appreciated that everyone in the CBHPC has a perspective and it will be important for the deciders to hear from all of us on these issues.

Regarding the diversion ask, Ms. Moore asked if there is an estimate for what kind of savings there would be on the corrections side in terms of not having to house these people for as long, or to deal with them in the correctional system. She also mentioned that with diversion, you lose the "lever" that is a promise of the individual in the judicial system to do better and follow through on treatment – if the individual fails, they might go to jail or something like that. Ms. Cabrera answered that a handful of counties have done some work in jail diversion and have seen amazing preliminary results, reducing costs on the law enforcement side and the hospitalization side. This is what we hope to study through this ask.

Mr. Ramirez asked about any conversations about instituting regulatory processes so that the Mental Health Services Oversight and Accountability Commission (MHSOAC) can begin to support successful counties and hold accountable failing counties. Ms. Cabrera responded that there were a couple of state audits that looked specifically at the issue of regulatory authorities and oversight of the MHSA. The findings had been negative regarding the MHSOAC and the Department of Health Care Services (DHCS). The overarching message was that they had fallen down on the job. Both agencies answer to two bosses which is very difficult. The CBHDA does share the frustration about the lack of oversight. We need stronger structure from the state on MHSA oversight. The list of what we need to do must be very clear so that everyone is on the same page.

Ms. Mitchell expressed concern that the CBHDA would promote such a fundamental change in the MHSA to allow payment for drug and alcohol services. At the time the original legislation was created, the strongest support for the MHSA came for full service partnerships (FSPs) for homeless persons with mental illness. This would be a fundamental change if MHSA money were allowed to pay for services for persons with SUDs who do not have a serious mental illness. Instead of promoting more money for SUDs, you are just taking money from mental illness. Realignment funding for mental health has been shrinking through the years. Ms. Cabrera responded that MHSA dollars have been funding about one-third of the mental health system. For some time, CBHDA has held the position to promote the idea of allowing for primary SUD to be funded under the MHSA. Our perspective is that if the client has a need for SUD services and has a

primary SUD diagnosis, and we have an FSP, we don't want to turn them away with the infrastructure we have built out with the MHSA. She understood the concern around the amount of money in the system, but there is significant overlap between individuals who have mental illness and who struggle with an SUD. Ms. Mitchell felt that the issue is funding for people who do not have serious mental illness, but only a diagnosis of an SUD.

Ms. Starkey asked about the LPS audit: how successful will advocacy to expand the definition be? What is CBHDA's perspective? Ms. Cabrera answered that they will have to see the proposed policy first. The overarching perspective is that in broadening conservatorship laws and allowing us to take in more people, we do not know where we would put them. There is zero capacity in the system to absorb the shift in conservatorship laws that are being proposed. One of the problematic key issues with the current structure is the lack of good data about what happens in this space. CBHDA supports adding state funding for the public guardians. The board and care proposal is related: if we shore up capacity and infrastructure, we won't have as much of a need for more drastic proposals.

Ms. Prettyman felt that first they need to know what they are going to do with the people who come off the streets – they need to get the plan structured. She added that we should bring back the Department of Mental Health (DMH). We have gone very far in many different directions since then. She suggested using the CBHPC to do oversight of the DHCS and the Commission.

Ms. Oseguera asked if there is anything that the Planning Council can do to help facilitate conversations in getting the counties what they need from the state. Ms. Cabrera said she would really like to work with the Planning Council to engage the communities more broadly in these conversations.

Mr. Leoni stressed the importance of data and computing power. With reference to the Governor's budget, it is easier to knock out one-time money. The counties and DHCS need new computer systems that can talk to each other.

Ms. Baylor noted that several years ago, DHCS did try to expand their oversight role, but the Department of Finance said no. Currently stakeholder voice can make a difference in this issue.

Public Comment

Amanda Nugent Divine, Kings View CEO, asked why the Governor voted against youth mental health first aid. Ms. Cabrera answered that CBHDA had cosponsored legislation to establish youth mental health first aid in the schools. This year they are back with a revised proposal.

Ms. Divine mentioned a program in which therapists go out in the field with law enforcement that is inhibited by HIPAA. Ms. Cabrera agreed that unfortunately federal laws create hurdles that we need to navigate from time to time in order to serve clients.

3. Approval of the October 2019 Meeting Minutes

Motion: Susan Wilson moved to accept the Minutes from October 2019; seconded by Dale Mueller. Motion carried with abstentions by Lorraine Flores, Darlene Prettyman, Cheryl Treadwell, Barbara Mitchell, Arden Tucker, and Marina Rangel.

4. Public Comment. None

5. ACCESS California and State of Community 2019

Andrea Crook, National Certified Peer Specialist (NCPS), Director of Advocacy, at ACCESS California, began the presentation by describing her background.

Ms. Crook stated that NorCal MHA is now known as Cal Voices. It is the oldest continuously operated peer-run consumer advocacy agency in California. They specifically hire individuals with lived experience.

ACCESS California is a program of Cal Voices; it is a consumer-led statewide stakeholder consumer advocacy program funded by the MHSA. It is overseen by the MHSOAC. ACCESS stands for Accessing Client and Community Empowerment through Sustainable Solutions. Their mission is *"to strengthen and expand local and statewide client stakeholder advocacy in California's public mental health system through individual and community empowerment."* Its values are advocacy, recovery, and peer support.

ACCESS wants to ensure that programs, services, and systems are embracing the recovery model of care, while always elevating and expanding the role of peer providers.

Based in Sacramento, ACCESS has tremendous support from ACCESS ambassadors throughout the state. Their role is to educate and empower community stakeholders, including those who historically may not have had an active role in their community.

They have just released their *Year 2 State of the Community* report. Ms. Crook shared findings from Year 1 and Year 2 and gave a historical timeline of ACCESS.

During Year 1 they looked at advocacy at the local and state levels. They looked at recovery-oriented services and systems, and how they are being measured. This year they looked at how peer support is being implemented and expanded throughout the state, what is working, and opportunities for growth. .

Methods used to assess the California public mental health system and the MHSA funding are:

- Stakeholders
- Stakeholder feedback surveys
- Local and state level leadership
- Clients and family members
- ACCESS ambassador boot camp evaluations
- Leadership training and community empowerment training in all five MHSA regions

In Year 1, the goals were to identify barriers to inclusion and participation, and to offer potential solutions and provide support in their implementation.

The MHSA calls for unprecedented amounts of stakeholder feedback. It is client-driven for the adult system of care, and family-driven for the youth system and care. With the MHSA's enactment, individuals have a new voice.

For General Standards, ACCESS focused on community collaboration and client-driven outcomes.

Regarding meaningful involvement, the Welfare and Institution Code (WIC) states, *"Counties shall demonstrate a partnership with constituents and stakeholders throughout the community planning process."* ACCESS took a look at whether that was being done. ACCESS found in 2018 that the representation on local mental health boards and commissions was not really upholding the intent of the WIC code.

In Year 2, the goal was to determine whether and to what extent the public mental health system is meeting clients' recovery needs; to identify actual or potential barriers to recovery orientation in the public mental health system; and to offer solutions and provide support in their implementation.

ACCESS received 694 responses to their surveys. The Substance Abuse & Mental Health Services Administration (SAMHSA) has a working definition of recovery: *"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."* Ms. Crook explained SAMHSA's four major dimensions of Health, Home, Purpose, and Community.

Recovery mandates come from WIC and the Regulations. They include the MHSA Recovery-Oriented Systems, the MHSA General Standards, the definition of *client-driven*, the MHSA definition of *integrated service experience*, and the FSP data collection requirements.

ACCESS asked if the public mental health system is meeting clients' needs and the MHSA mandates. The results showed a low C or high D average. They also asked what recovery-outcome data collection tools are used. 72% of those from the state who responded said that they do not collect any recovery outcome data; from the county and local level leadership, 59.5% said they do not.

County-level recommendations that ACCESS gave to the counties were to invest in the community program planning process. Counties are allowed to spend up to 5% of their annual allocation on community planning; there is no floor. Only a handful of counties are even reporting spending money on the Community Planning Process (CPP). ACCESS also wants counties to give their definition of CPP. They want the counties to develop a shared power framework for stakeholder participation within CPP, and provide training. Ms. Crook continued discussing the recommendations for the counties.

She noted that the World Health Organization put out an Advocacy for Mental Health toolkit in 2003 right before the MHSA passed. They said that advocacy groups need independence from government in order to achieve their goals. Although counties are creating these advocacy positions, many of them are being created in-house. It is

important for advocates to have autonomy from the government, although they need close working relationships.

Another county recommendation is to expand peer support services and increase opportunities for peer advocacy. Not everyone realizes that one of the items that innovation can be used for is advocacy.

State-level recommendations are for DHCS, MHSOAC, and legislative priorities.

- For DHCS to require counties to allocate up to 5% of their annual MHSA funding to the community planning process; to develop a review process to scrutinize the quality and quantity of client stakeholder involvement; and to convene a client leadership panel to develop benchmarks for the community planning process, participation and incorporation of the MHSA General Standards and all MHSA programming.
- For the MHSOAC to require counties again to allocate for their CPP and innovation; to develop a review process to scrutinize the quality and quantity of involvement; to create a stakeholder leadership committee; and to create at least one nonvoting seat from the Client and Family Leadership Committee and the Linguistic Cultural Competence Committee.
- Legislative priorities:
  - To create clear guidelines and enforcement mechanisms around the requirements for counties to utilize up to 5% of their annual MHSA funding for CPP.
  - To require that each county's MHSA CPP be comprised of a committee or advisory body that is subject to the Brown Act.
  - To require that each county's MHSA CPP be comprised of a committee or advisory that reflects the ethnic diversity of the client population, and is at least 50% client and family members.
  - To establish a minimum percentage or ratio of peer provider positions to clinical provider positions in county mental health systems.
  - To develop a standardized definition of the identified peer roles.
  - To require each county to fund a full-time designated client advocate position.

Ms. Crook gave a historical background of the MHSA. She posed the question: If the MHSA was intended to transform the public mental health system, what happened?

1. Fragmented oversight. Tasking multiple agencies with MHSA oversight created great confusion and procedural inefficiencies.
2. Phased implementation. The DMH implemented the MHSA in phases, so the plans were not integrated and there was an MHSA funding backlog. Counties could not develop their component plans or get MHSA funds for the components until DMH released its guidelines. Then, to expedite the flow of MHSA dollars, DMH began paying 75% of MHSA funds to counties prior to reviewing and

approving their MHSA plans. This did not resolve the accumulation of unspent funds at the state level.

3. The Great Recession. It created a statewide budget deficit of over $57 billion in 2008, resulting in massive budget cuts to state and county agencies. The recession's effects continued into 2011, resulting in the Legislature passing $27 billion in budget solutions, including restructuring funding mechanisms for state and local services – Realignment. Governor Brown eliminated DMH in 2012 as redundant. The transfer of MHSA oversight to DHCS exacerbated the shift in MHSA funding priorities from recovery-based services and integrated care to medical model services and a maximization of Medi-Cal FFP draw-down.

Currently ACCESS has a concern about the client/family voice being lost.

Questions and Discussion

Ms. Baylor asked to confirm there had been a diversion of $864 million in MHSA to Early Periodic Screening, Diagnosis and Treatment (EPSDT) during the financial downturn, done because the money was in the state coffers and the Legislature wanted access to it, and also to prevent a lawsuit. Ms. Kelley confirmed.

Ms. Moore asked if the local planning boards were the designated entities for setting local priorities for the MHSA. Ms. Crook explained that the mental health board is not the steering committee, but some mental health boards have a subcommittee that is the steering committee. Because counties are required to set up a steering committee, if it is not done under the Board of Supervisors, it does not fall under the Brown Act. Having the steering committee a subcommittee of the local mental health board, or separate, is up to the county.

Chair-Elect O'Neill noted that when the recession hit, the counties were struggling just to maintain their programs. It is an underfunded system and counties needed the MHSA to provide vital services for consumers. Because of the restrictions around the innovation programs, there was a buildup of money and taxpayers were upset about that – the counties were not allowed to spend their revenue. Chair-Elect O'Neill appreciated the work ACCESS is doing to try to revitalize MHSA.

Ms. Frey stressed that high schools need peer programs; teens listen to other teens. Until we have it in our schools, fear will inhibit our understanding of youth mental health.

Mr. Shwe asked for Ms. Crook's recommendations for the Planning Council. She replied that ACCESS wants to work with the Planning Council to ensure that the MHSA does not lose its original intent. We have shared priorities.

Ms. Hunter thanked Ms. Crook for validating what is happening: the loss of the voices of consumers and family members.

Mr. Leoni mentioned efficiencies at the state level. As far back as 2009, DMH was asked to pull back from communities (although the advocacy voice of the Planning Council remained intact because of federal mandate). He noted that the original Realignment happened in 1991; all of its growth funds went to Social Services. The 2011 Realignment was meant to backfill the dwindling funds. Also in 2011, DHCS began talking about

realignment of MHSA. Word went out at the state level for the counties to do oversight, and there was no real leadership at the center.

Ms. Prettyman shared that the Consumer/Family Leadership Committee at the MHSOAC had been wonderful. Along with the Cultural Competency Committee, they did stakeholder meetings all over California. These meetings were eventually stopped. The committee still meets but members cannot be paid for traveling to the meetings. The Planning Council should take up this issue – we need to be at the table, but we should be paid for traveling there as that is part of MHSA funding.

6. Public Comment

Barbara Wilson expressed a concern about an attitude of privilege of using MHSA funds for "higher-functioning" clients or early psychosis clients versus those not involved with drugs and alcohol, but who have serious and chronic forms of mental illness. Also, families need to have a single point of contact that is consistent – someone who already knows their story.

Stacy Dalgleish asked if it would be possible for the counties to have a yearly communication of three points to work on for the year. They could take the three points into consideration when formulating their yearly plan. Ms. Crook responded that ACCESS is not a program that tells communities what they need; their goal is to educate and empower stakeholders. Every community's needs are unique. ACCESS provides tools and resources to have a shared power framework. They can help the counties put together a one to two-page outline of priorities.

7. Update on Policies/Procedures Changes

Chair-Elect O'Neill reviewed four matters the executive team has been working on.

1. Length of term for Chairperson. By the time the Chairperson gets up to speed, they term out. The Executive Committee has amended the term of office from one to two years.
2. Length of term for Committee Chairs. The Executive Committee voted for a term of office of one year; committee members may choose to nominate the current Chair and Chair-Elect for a second term for a maximum term of two years.
3. Attendance of Council Members at quarterly meetings. The Executive Committee voted that Council Members are to attend all quarterly meetings in full. When a pattern of nonparticipation occurs, it will be addressed by the Council Chairperson and Executive Officer. Should the pattern of nonparticipation continue, the member will not be eligible for re-appointment.
4. Committee meeting attendance requirements. The provision addresses the circumstance where it is difficult for the committee to gain a quorum, and there is a repeated pattern by a Council Member of missing meetings. A Request for Leave of Absence can be submitted to the Executive Officer.

Mr. Ramirez asked for the Planning Council to ensure that a policy is in place to comply with the federal regulations in the Americans with Disabilities Act. Chair-Elect O'Neill

agreed. Executive Officer Adcock asked Council Members to inform staff of any necessary accommodations.

Ms. Mojica de Tatum asked when the committees meet that were referred to by Chair-Elect O'Neill. He answered that they meet during quarterly meetings, plus possible in-between meetings.

Chair-Elect O'Neill announced that Raja Mitry has resigned from the Planning Council due to medical reasons. Susan Wilson has agreed to return and serve as Past Chair.

8. Public Comment. None

Friday, January 17, 2020: Council General Session

1. Welcome and Introductions

Chairperson Flores opened the meeting. The Planning Council members introduced themselves.

2. CA Association of Local Behavioral Health Boards/Commissions Update

Theresa Comstock, CALBHBC President, provided the update. She introduced the members present, including Planning Council members on commissions and boards: Mr. Ramirez, Ms. Caffey, and Ms. Mojica de Tatum.

Ms. Comstock reminded the Planning Council of CALBHBC's role in supporting the boards and commissions. 90% of what they do is providing resources and technical assistance, taking questions, providing training materials, etc. About 10% is advocacy.

At the top of the priority list for CALBHBC is identifying performance outcome data. Ms. Comstock showed the other priorities on the list: workforce, residential care facilities, the crisis care continuum for all ages, employment, and children/youth.

Regarding performance outcome data, CALBHBC decided to go through every county's MHSA plan or update to look for the data. They compiled a spreadsheet and noticed that every county had a different way of reporting; also, the measures they reported on were different. CALBHBC is advocating for standardization and identification of points of data on which to report. DHCS and MHSOAC should have coordinated this long ago; the Planning Council should be involved in the effort.

Although state leadership is considering a refresh of the MHSA, they do not know the performance of the system. This does not make sense.

Ms. Comstock indicated the resources on the CALBHBC website.

Questions and Discussion

Chair-Elect O'Neill commented that the better we can tell the story of the successes of MHSA, the more our families and consumers will benefit. We know that there is a deficit in understanding in the community of the value of MHSA. He noted that performance outcome data from DHCS is extremely scarce. However, the Planning

Council has a Performance Outcomes Committee that has just put the finishing touches on the 2018 Data Notebook; it made a significant inquiry into those areas of services as mandated by WIC. Ms. Wilson commented that about 50 counties responded. Chair-Elect O'Neill emphasized that CALBHBC has been instrumental in helping the Planning Council to gather this data.

He requested that when the Planning Council members receive the Data Notebook electronically, they take a look at it.

Ms. Wilson stated that the committee is working on identifying a group of performance measures that they can track. (They themselves do not collect any data.)

Ms. Moore asked if we are getting our data from those same reports, or does the CALBHBC compilation give some additional depth? Ms. Comstock replied that for the MHSA they had to compile it themselves – it was rambling but they were able to summarize the data points. External Quality Review Organization (EQRO) data was easy to access; CALBHBC found where the outcome data was within those large reports and listed the page numbers. Mental health boards can easily find that data now. There is also some data from the SAMHSA PATH grants on employment and housing.

Ms. Comstock explained that EQRO analyzes the Medi-Cal programs in the counties and does an annual report.

Chair-Elect O'Neill asked Ms. Baylor about the difficulty it has been to have statewide data. She said that EQRO gets claims data and California Outcomes Measurements System (CalOMS) data from the state, and they try to put it together (CalOMS is on the substance use side). Once a year EQRO does an annual report, compiled and presented by region.

Mr. Leoni spoke as an advocate: the inconsistencies, confusion, and lack of data has been a major concern. He also clarified his comment yesterday during the discussion with the CBHDA Executive Director regarding the one-time expense to upgrade the antiquated computer at DHCS and the county computer systems, so that they can all talk to each other – which would make data sharing more easy and consistent.

Ms. Prettyman suggested having the behavioral health boards agendize a presentation on the Data Notebook so that they can all understand that it contains valuable information. Ms. Wilson stated that the committee had discussed getting on the CBHDA agenda to speak about the Data Notebook. They are also developing new strategies for when they mail it out. Ms. Comstock stated that CALBHBC now does statewide teleconferences that are opened up to the boards and commissions. When there is a new Data Notebook, they could include it as a topic and reach all 59 counties at one time.

Ms. Shaw noted that the Planning Council's only real authority is to review and approve the Performance Outcome Indicators. When was the last time we did that? Ms. Wilson stated that the Performance Outcomes Committee is looking at that topic now.

3. Committee Reports

Workforce and Employment Committee

Chairperson Dale Mueller provided the report. She acknowledged John Black's suggestions and help.

- Over the past year the committee has been exploring successful models of supportive employment. They heard a presentation yesterday on The Meeting Place, a clubhouse model in San Diego with three types of employment programs: transitional, supported, and independent.
- They will be planning presentations on employer culture and entrepreneurial/ creative endeavors.
- They heard a presentation from OSHPD, who will be reporting on progress in implementing their plan and their ideas about gathering outcomes data.
- They had a call-in from CBHDA on SB 803, Peer Support Specialist Certification. There was committee consensus for writing another letter of support.

Legislative Committee

Chairperson Gerald White provided the report.

- Tony Vartan will be the Chair-Elect.
- Liz Oseguera gave a presentation on the public charge rule. The recent change will have a chilling effect on undocumented and documented who will be concerned about their ability to become citizens later if they use health benefits. Ms. Oseguera explained that many patients from the immigrant community may be scared to access public benefit programs such as food stamps, the Women, Infants & Children (WIC) program, and Medi-Cal for fear that their information may be shared with ICE and their use of benefits may prohibit them and their family members from adjusting their status in the future.
- The committee reviewed its policy platform.
- They took a cursory look at SB 855, another parity attempt.
- They heard a presentation by the CBHDA Director of Government Affairs.
- They discussed the looming specter of a mutated MHSA.

Patients' Rights Committee

Chair Walter Shwe provided the report.

- The committee heard a presentation from the Defense Transition Unit of the San Diego Public Defender's Office, which links people who are leaving jail with mental health professionals.
- The committee intends to develop a survey directed at the local mental health boards and commissions about patients' rights advocacy in jails.
- The committee's composition is set by state statute: five Planning Council members and two voting ad hoc members.

Housing and Homelessness Committee

Chairperson Vera Calloway provided the report.

- The committee heard a presentation from the Director of the San Diego Office of the Corporation for Supportive Housing, and the Deputy Director of Mental Health for Adults and Older Adults for San Diego County. They spoke about their collaboration on supportive housing and improving systems as solutions to homelessness. They highlighted the Frequent User Systems Engagement (FUSE) model, which flags high utilizers of homeless, housing, and mental health services.
- The committee will be putting the finishing touches on a white paper on Innovative Housing-Related Programs.
- They made some revisions to their work plan, adding adult residential facilities so they can make recommendations to influence upcoming decisions.
- They amended their objectives on the Housing First project. They are reviewing legislation that mandates using Housing First policy at a state level to make recommendations for potential change.
- The Chair-Elect is Monica Caffey.

Systems and Medicaid Committee

Chair Liz Oseguera provided the report.

- The Chair-Elect is Karen Baylor.
- The committee heard a presentation from the Executive Director of CBHDA on CalAIM and the county perspective.
- Ashneek Nanua did a crosswalk between the stakeholder response from the October event and the CalAIM changes coming up. The committee will have a teleconference in February to finalize priorities and recommendations.

Performance Outcomes Committee

Chairperson Susan Wilson provided the report.

- The committee has finished the 2018 Data Notebook Report whose topic was the Continuum of Care services being provided by county behavioral health as required by statute. They have added recommendations to the report.
- The staff have assessed the responses for the 2019 Data Notebook; its topic is trauma-informed care. They have 30+ responses so far, 14 pending, and a report is in process.
- The general topic for the 2020 Notebook is employment.
- The committee has identified and is formalizing some performance measures they want to track.

Ms. Moore suggested including the Data Notebook as an agenda item for an upcoming General Session.

Chairperson Flores commented on the breadth of expertise among the Planning Council members that can be tapped into.

Children/Youth Workgroup

Noel O'Neill provided the report.

- The workgroup heard a presentation from Christine Frey on Brain XP.
- They discussed AB 2083. Cheryl Treadwell and Kathi Mowers-Moore spoke about what the Department of Rehabilitation and the Department of Social Services are doing. The bill provides for joint leadership around behavioral health issues to prioritize foster children.
- The workgroup affirmed the goal of ensuring that the youth voice is heard in all Planning Council matters, including death by suicide rates.
- Kathi Mowers-Moore stated that recently all counties received notification to initiate MOUs with Behavioral Health, Education, Department of Rehabilitation, Department of Social Services/Child Welfare, and Department of Developmental Services. The MOU is intended to mitigate the gaps and infighting between agencies as to who should pay for what foster services. This is a key time for local people to develop collaboration.
- Cheryl Treadwell commented on the conversation and leadership from the Agency Secretary about data, allowing the departments to be more thoughtful about how to do data exchange.

Reducing Disparities Workgroup

Sokhear Sous provided the report.

- The workgroup discussed looking into the report from Alameda County Behavioral Health through the MHSA and UC Davis; they are doing a study in Solano County. The workgroup would like to give a presentation to the full Planning Council in the future.
- The workgroup is trying to recruit more members.

Council Member Conference Reports

Mr. White reported that he, Chair-Elect O'Neill, and Ms. Wilson had attended "Rooted in Community: Moving from Trauma to Healing" presented by Public Health Advocates. The keynote speaker was Dr. Michael Eric Dyson. Chair-Elect O'Neill said that one of his main takeaways had been that in trying to resolve trauma in children and families, we must look at not only individuals but also communities – to figure out ways to mitigate stresses, particularly undue stresses, to particular populations.

Chair-Elect O'Neill attended the fourteenth annual Psychosis Conference in Sacramento, sponsored by UC Davis. He took extensive notes which he is happy to share. One

keynote speaker, psychiatrist Dr. Albert Powers, spoke about the phenomenon of hallucinations. At Yale they are experimenting with the fact that some hallucinations can be controlled. They also heard from a UCLA psychologist who addressed suicidality in youth. For youth, suicide will always be the greatest cause of death; catching kids early when symptoms are new is critical. They heard from Dr. Tom Insel, who spoke about access to services, quality of services, and the data collected by those services, as well as digital tools as a possible factor in assisting in health care. They heard from psychologist, Tyler Lesh, about cannabis use by adolescents harming their neurological development.

Mr. Black recognized Ms. Nanua and Executive Officer Adcock for traveling to Modesto to attend community events: Art & Music on the Plaza and the 20th Anniversary of the Motown Boogie.

Mr. Ramirez attended the Native American/Alaska Native Mental Health Conference. Increasing rates of death by suicide are a disturbing trend that is impacting the community, as is the epidemic of murdered and missing indigenous women. The community is working for empowerment. Housing and the dropping penetration rate were also key topics at the conference. Mr. Ramirez also attended the National Disability Rights Network Conference in Florida. Attendees looked at how global warming is affecting all of us. They seek to ensure that people with disabilities are at the table.

Ms. Frey spoke at the 10th Annual Integration Summit in San Diego. San Diegans are working on the integration of behavioral health and primary care.

4. Meet New Region IX SAMHSA Regional Administrator

Chairperson Flores introduced Captain Emily Williams, the new regional SAMHSA administrator. She provided an overview of herself, her interests, and SAMHSA's work.

She spent 22 years in the Indian Health Service, primarily as a clinician in the field working with children and families in some areas with a very high rate of death by suicide. Addressing health disparities for minority youth, particularly Alaska Native and American Indian children, is a passion of hers.

SAMHSA has ten regions. Captain Williams is based out of San Francisco. Region IX covers California, Arizona, Nevada, Hawaii and all the Pacific Islands and jurisdictions.

SAMHSA's role is to provide leadership and guidance; they do not do clinical work. Its mission is to reduce the impact of substance use and mental illness on America's communities. Captain Williams explained the organizational structure.

People impacted with psychological and behavioral health issues so often do not feel like anyone hears them. The Planning Council is their voice, and Captain Williams is here to listen to the Planning Council as their voice.

Her passion lies in community prevention and health promotion.

SAMHSA strives to move evidence-based practices forward.

Captain Williams listed discretionary grants that SAMHSA offers on a yearly basis. They are available not just for state agencies, but also for non-profits, schools, and communities.

She listed evidence-based services and technology transfer centers that SAMHSA offers. Partnership in information-sharing is very important.

Questions and Discussion

Mr. Ramirez greeted Captain Williams in the Shikoba tongue and stated that the Protection & Advocacy for Individuals with Mental Illness Advisory Council is looking forward to collaborating with her.

Ms. Calloway asked, since peer support is an evidence-based practice, does SAMHSA have any involvement or influence in the Peer Certification bill in California? Captain Williams answered that as an agency, SAMHSA advocates for peer support networks and trainings. One area of concern is the ablility to bill for that service – it creates sustainability in the programs.

Ms. Tucker asked if SAMSHA has any outreach with the deaf and hard of hearing community. Captain Williams replied that she would find out.

Ms. Baylor asked about SAMHSA's support for naloxone and medication-assisted treatment of opioids. Also, there has been a huge rise in meth use, and there is no medication-assisted treatment; where is SAMHSA in that space? Captain Williams replied that the block grants for the coming year will have language to include other substance uses of amphetamines – there will be opportunities for states to incorporate different types of treatments. She has seen that in Indian country and rural communities west of the Mississippi, meth, rather than opioids, were the primary problem.

Ms. Moore asked about SAMHSA resources for the topic of jail treatments and the lack thereof. Captain Williams responded that SAMSHA is looking at the advocacy issue of bringing medication-assisted treatment into jails. Many of the jails in California are embracing screening and treatment. She offered to connect Ms. Moore to the technology transfer center here.

Mr. Leoni commented that the client/family community, particularly the clients and particularly at the state level, have become somewhat disorganized in recent years. Significant decisions are being made at high levels with very little client or family input. He would like to rebuild that voice in California, and working with SAMHSA for some of the grants might be a way to start that process. Captain Williams agreed that the pendulum has swung away from client/family representation; she is hoping that it is now swinging back towards the middle. She would like to connect with consumer groups within California to hear their concerns and push them forward.

Ms. Mitchell asked if SAMHSA has published any resources for effective methods for keeping people housed who are methamphetamine addicts or regular users. In her local homeless community, this is one of the most major impediments to getting and keeping people housed. Housing and Urban Development (HUD) has come up with zero resources and best practices. Captain Williams stated that SAMHSA has no resources

but she will bring this concern back to them. Ms. Mitchell added that the success rate in keeping regular methamphetamine users housed is extremely low.

Ms. Frey asked how SAMHSA focuses on building communities for teenagers, youth, and Transition-Age Youth (TAY). Captain Williams answered that there are some youth connection grants available specifically for children, adolescents, and TAY.

Mr. Black described how the pendulum has swung through the years between wellness, recovery, and community. Some effective community centers working on small budgets no longer exist because of the pendulum swing, but many individuals who were connected to their natural community are doing just fine. Captain Williams commented that the topics change and the buzzwords change, but the people out in the trenches doing the work (such as the Planning Council) are still here.

Ms. Shaw felt it important for people to realize that there is a Public Health Service of which Captain Williams is an officer. Captain Williams explained that the Public Health Service began in 1798 as one of the seven uniformed services. It comprises professionals who have something to do with health care: doctors, nurses, social workers, mental health providers, and a variety of engineers and therapists. The majority of officers work in clinical roles within the Indian Health Service, the Bureau of Prisons, Immigration Health Care Services, and other agencies providing health care such as the Food and Drug Administration and Centers for Medicare and Medicaid Services.

Public Comment

Richard Krzyzanowski of Disability Rights California stated that even those with severe conditions have voices both collectively and individually; he hoped that systemically, everyone gets better at listening. Regarding Captain Williams' mention of "the impacts of mental illness on society," we tend to focus on people who are severely ill, but the community of people with psychiatric conditions as well as the disabled community are very diverse. We have degrees of wellness and recovery as well as degrees of successful participation in society. We are making contributions of value not only despite our disabilities, but also because of our disabilities as we overcome challenges and gain experience.

Barbara Wilson asked about the concept of getting ahead of having mental illness and behavioral problems versus treating them after the fact. Captain Williams agreed that she looks for prevention opportunities. Ms. Wilson asked about brain treatments that are not connected with chemical use such as medications, such as neurofeedback. Captain Williams indicated resources that are available: research coming out of the National Institutes of Health show that brain science is being developed and expanded.

Stacy Dalgleish voiced a concern: she ascertained that Captain Williams' chain of command leads up to the Surgeon General. With the turnover at the Cabinet level of this Administration, how will that affect us at our human level in terms of continuous funding? Captain Williams answered that SAMHSA works toward expanding budgets for anything to do with substance abuse and mental illness. As an agency, they are not allowed to lobby for specific funding, but they are able to put forward the concerns of communities to the Secretary.

5. Department of Health Care Services Update

Dr. Kelly Pfeifer, MD, stated that DHCS is going through robust engagement in trying to understand what is not working well, particularly in the Medi-Cal program, and what a program of the future would look like that follows through on the promise. DHCS needs collaboration and pressure from the Planning Council and the public. Dr. Pfeifer appreciated the earlier statements on data. How do you go from the morass of data to a set of measures that is meaningful for people, families, and communities? Some of the beauty of the MHSA is local governments and the local responsive process to determine where those monies should be spent. However, it makes it difficult to tell a statewide story with every community doing things differently.

Dr. Pfeifer stated that she is committed to being pragmatic about the world we live in, where there is a tremendous amount of local control. How can we push as far and as fast as possible to do the right thing by the people suffering from mental illness and substance use disorder?

She feels that we have a Governor and Secretary who are visionary, and leadership at DHCS who are in alignment for tackling big problems such as homelessness, a criminal justice system that incarcerates rather than offering treatment, and kids facing trauma. We now have these two waivers with which we can go to the federal government and ask to do things differently. CalAIM is an ambitious roadmap.

Dr. Pfeifer has frequently heard that it does not work to pay providers by the minute, and then have everyone on the provider team trying to document everything that happens by the minute.

Dr. Jim Kooler, the new Assistant Deputy Director, shared his background in working for youth.

Questions and Discussion

Ms. Baylor asked when Dr. Pfeifer's confirmation will happen. She replied that she has 364 days to be confirmed, and she started the job August 5. She has received tremendous internal and external support. She acknowledged that there is a great deal of change underway among the top level DHCS staff; however, there is great stability beneath that level – middle management is strong. She allowed that this much change is hard on department morale.

Ms. Baylor asked if it is possible for the Planning Council staff to get the behind-the-scenes org charts of DHCS. This would be helpful because it is hard to know who to go to now. Dr. Pfeifer said she would look into the delay. The three go-to people are Brenda Grealish for Medi-Cal, Marlies Perez for community services and public non-Medi-Cal funding, and Janelle Ito-Orille for licensing and certification.

Mr. Ramirez asked how the Latino population is being involved in the state planning process and quoted the motto, "Nothing About Us Without Us." He requested DHCS to pause and re-engage with the Latino, Native American, and LGBT community. Dr. Pfeifer stated that DHCS has several ways for people to give input: the Planning

Council, public comment in meetings, emails, and invitations to talk with various advocacy groups.

Mr. Black commented that the complaint process for MHSA is not clear. There needs to be an arbitrary person or organization that can handle complaints from consumer organizations that can fall by the wayside because of political and personality conflicts. Also, Mr. Black brought to the attention of the Planning Council the formation of Lifestyle Medicine practitioners and the certified Lifestyle Medicine branch of the American Medical Association. He offered the data that the leading cause of death for consumers is not suicide, but heart disease, obesity, and cancer. He wants to get away from the current phase of self-care and into planet care.

Chair-Elect O'Neill commented that the youth of Trinity County loved the Friday Night Live program; he expressed the hope to Dr. Kooler that we could get a better handle on EPSDT for youth substance use treatment – it really has some holes in it. Chair-Elect O'Neill expressed to Dr. Pfeifer the need to establish reimbursement for peer respite. Dr. Pfeifer requested any information on good peer respite programs from the Planning Council members.

Mr. Leoni made three points. First, the former CalAIM has a meeting scheduled at the same time next week as the MHSOAC; he requested a switch in the schedule. DHCS should be cognizant of major meetings. Second, there seems to be no intentional effort to involve clients or family members in the stakeholder process at DHCS. Third, he brought up the topic of data – he espoused "21st century" use of data. What was collected 30 or 40 years ago might not be what we need now. A way of gaining more flexibility is use of electronic health record software called The Registry, now an innovation project in Modoc County. The health records go automatically into a data warehouse where data is tagged so that you can draw on it later in flexible ways.

Dr. Pfeifer responded that it is too late to change the meeting time, but there are many methods of contributing feedback. Several of the workgroups involved are repetitive; DHCS will be working through more refined proposals. Regarding consumer presence at the meetings, Dr. Pfeifer agreed that DHCS has not done well in the past and is looking to do better. Regarding data, Dr. Pfeifer agreed that behavioral health is definitely behind. Her team has an effort called Behavioral Health Data Modernization. The process to fix the data system is long and arduous, and they are completely committed to starting it. An example is the fair public criticism about how counties are using MHSA dollars – did DHCS revert money that is not getting spent? All those reports are entered manually at DHCS. DHCS has set up processes for reversion and is now confident that counties are using money as they should.

Ms. Treadwell was pleased to hear about the focus on children and youth. She hoped that DHCS builds a true infrastructure for children, and also remembers young children in terms of prevention. Dr. Pfeifer agreed that our two departments need to have a better system of care for high-risk youth.

Mr. Black commented that although prevention is doing well, we still have some gray areas. Older populations who are at risk for suicide are growing; don't forget the elder

population. Dr. Pfeifer agreed – half of the homeless population over the age of 50 were not homeless before age 50.

Ms. Moore noted that in the recent past there had been no connection between the California Psychiatric Association (CPA) and DHCS. She pointed out that the CPA had been in favor of integrating DMH with DHCS. The practical ramifications of losing DMH have been devastating. She felt heartened that DHCS is continuing to attend the Planning Council meetings, and was pleased with the report that the Systems and Medicaid Committee reviewed. Ms. Moore was also pleased that the DHCS participation at the committee meeting showed that they are data-driven. Given that integration with health care is important, Ms. Moore exhorted DHCS to keep mental health active and significant. Dr. Pfeifer requested the Planning Council to keep DHCS informed. The *Medi-Cal Healthier California For All* report shows that mental health and SUDs are high profile for DHCS, this Administration, and the Secretary.

Ms. Oseguera asked about the timing for the Systems and Medicaid Committee to submit comments to help influence the waiver discussions now occurring. Dr. Pfeifer replied that the sooner the better. Many of the big policy decisions need to be locked in by the close of the stakeholder process at the end of February.

Ms. Baylor asked Dr. Pfeifer's thoughts on where she sees MHSA going and some of the proposed changes. She replied that there are many very opinionated people involved and she did not know what is going to prevail. There are concerns on the part of state leadership about massive amounts of money being spent in ways we cannot see or hold accountable and that may not solve some of our biggest problems across the state. It is very political. Whatever we do now will have some unintended consequences downstream, so we need to be thoughtful about ensuring that while we fix problems that we do not break things that are currently working.

Mr. Shwe noted that the Planning Council has the authority and responsibility to review and approve any new performance outcome measures that DHCS develops. We need to be part of the loop when those things come down. Dr. Pfeifer responded that she and Executive Officer Adcock meet regularly, and that she and/or Dr. Kooler will be present at Planning Council quarterly meetings.

Ms. Mowers-Moore commented that as one of the state representatives on the Planning Council, she finds it valuable to be represented not just at the General Sessions but also at the committee meetings. She encouraged DHCS to have a member at the table consistently. Dr. Pfeifer responded that with the lift we are doing around what used to be called CalAIM, it is difficult for her to pull out staffers for three days, but she will work with Executive Officer Adcock to ensure that they are here for at least part of the meetings.

Chair-Elect O'Neill commented on the MHSA refresh: if state leaders direct counties to use MHSA in avenues that are not really relevant to a small county, the services that are being provided to all four age groups of FSPs may not be able to continue: small counties count on MHSA to draw down federal financial participation. If that is lost, he hoped for replacement funding so they can still draw down Medi-Cal funding.

Ms. Prettyman spoke regarding the consumer/family member representation that is not happening. The MHSOAC used to have a Consumer/Family Leadership Committee that offered suggestions and advice to the MHSOAC. It held stakeholder meetings all over California and brought back wonderful information. The committee is still meeting but expenses are not paid, and some who attend the meetings are experiencing great hardship. Consumers and family members need to be embraced and heard – they are living the experience. Executive Officer Adcock clarified that Ms. Prettyman was addressing the MHSOAC and not the Planning Council with this issue.

Ms. Moore commented that local control of the MHSA does not preclude having common data outcomes. The local way of getting there does not have to be prescribed. Dr. Pfeifer agreed. A set of statewide priorities will lead to a statewide set of goals and metrics. Voluntary alignment among the counties is possible in their reporting. Ms. Moore stated that a significant concern is parity – the full plethora of evidence-based practices are not available on the private side. Hospital beds are very personnel-intensive and the payment system affects why they are closing.

Ms. Oseguera asked if the new Behavioral Health Task Force will have stakeholder involvement, and whether the Planning Council will have a seat. Dr. Pfeifer answered that she will check and report back.

Mr. Ramirez commented that people with mental health conditions are often not recognized in the health system as having a disability and entitled to accommodations. The MHSA failed to enforce that the programs it funded require ADA compliance.

6. Public Comment

Andrea Crook, ACCESS California, emphasized that it is disheartening and shameful that there is no client representative or organization seat on the Behavioral Health Stakeholder Advisory Committee.

Jean Harris stressed that recovery and the medical model must both be addressed; we must include genomics, nutritional psychiatry, alternative medicine, and functional medicine. We need to address homelessness with social enterprise. Youth is where we need to focus with on-campus clubs and normalizing talking about our mental health instead of stigmatizing it as society does. Further, there is still a block about addressing co-occurring disorders.

Kathleen Murphy congratulated Dr. Kooler and commented that we are in good hands.

10. Adjourn

Chairperson Flores adjourned the meeting at 11:43 a.m.

TAB F

California Behavioral Health Planning Council
General Session
Friday, January 21, 2021

Agenda Item: Member Discussion of 2021 Council Priorities

Enclosures: none

Background/Description:

The year 2020 brought a public health emergency due to COVID-19, widespread economic distress and increased advocacy against racial injustice. California's public behavioral health system has felt the effects of all three.

Each member is asked, within 30 seconds, to present their thoughts on the following question:

In light of what has happened over the last 12 months, what do you see as the priority for the Council in 2021?